

medicaid  
and the uninsured

February 2011

Helping Consumers Manage Long-Term Services and Supports in the Community:  
State Medicaid Program Activities

## Executive Summary

The Medicaid program is a source for many innovative practices in making long-term services and supports (LTSS) available to consumers. Jointly financed by the states and the federal government, Medicaid pays for 40 percent of LTSS spending the United States. Case management services have been integral to Medicaid community-based LTSS programs since their inception, but as the programs have grown and evolved, particularly as options for care have increased and consumers have taken a more active role in directing services, the functions performed by case managers have changed. Drawing on the professional literature and interviews with state officials, this brief describes current case management efforts in states and activities and policies that can enhance states' efforts to help consumers manage the services and supports they need.

**Key Findings:**

- **States are looking to person-centered rather than program-centered case management.** With the array of expanded service options and greater recognition that individuals' needs are not static, states are placing emphasis on planning around a person's current and changing preferences and needs. This requires case managers to be more familiar with the range of available services and supports than they would be if they worked with just one program.
- **A variety of strategies are used to achieve continuity for consumers.** These include assignment of a single case manager; use of electronic systems that make the notes of one professional immediately available to others; consolidation of Waiver programs to promote seamless case management if consumers move from one setting to another. When housing, relocation, or transition specialists are involved, states have developed systems to facilitate communication among them and other case managers.
- **Conflict-free case management is an important goal.** A provision in the Affordable Care Act promotes conflict-free case management. The intent is to eliminate potential conflicts of interest that may occur when a service provider employs the person who helps make determinations about or arrangements for services and supports. Currently, the extent to which this occurs varies among states.
- **Case managers need ongoing training and support.** Experience in states suggests that the attitudes, beliefs, and practices of case managers can have an impact on the choices consumers make and can affect the success of states' efforts to change LTSS systems. Thus, training may be needed as new programs or initiatives, such as those that feature consumer direction, are introduced. Also, as policies change, case managers may need detailed information and ongoing training to ensure that new policies are implemented effectively.

As state Medicaid programs consider how to best provide case management, the key issues states will have to address include: clear definitions of case managers' roles and responsibilities; reimbursement policies that foster person-centered services; and arrangements between case managers and service providers that do not risk conflict of interest. Looking ahead, with the implementation of the ACA and the growing population in need of LTSS, case managers will continue to play a key role in ensuring access to home- and community based long-term services and supports.

## HELPING CONSUMERS MANAGE LONG-TERM SERVICES AND SUPPORTS IN THE COMMUNITY STATE MEDICAID PROGRAM ACTIVITIES

### INTRODUCTION

The Medicaid program is a source for many innovative practices in making long-term services and supports available to consumers. Jointly financed and administered by states and the federal government, Medicaid pays for 40 percent of LTSS spending in the United States.<sup>i</sup> The shift from institutional to community-based services and supports financed by Medicaid is one obvious trend in recent years. Almost half of LTSS financed by Medicaid (45 percent) were community-based in 2009 compared to about one-quarter (24 percent) in 1997.<sup>ii</sup>

Case management services have been integral to Medicaid community-based LTSS programs since their inception, but as the programs have grown and evolved, the functions performed by case managers have expanded and changed. This has occurred as options for LTSS have increased and as initiatives to promote self-direction have been introduced. The role of case managers is mentioned specifically in the Affordable Care Act<sup>iii</sup> (ACA), which establishes the *State Balancing Incentive Payments Program*, a Medicaid option that will provide enhanced federal matching payments to eligible states that make certain operational changes, including the establishment of “conflict-free” case management services and use of core standardized assessment instruments, practices that will be the subject of forthcoming guidance from the Centers on Medicare and Medicaid Services.

Broadly speaking, case managers perform a range of activities to help ensure that the long-term services and supports individuals need are available in the most appropriate settings and that this is accomplished in the most effective and efficient manner. Traditionally, case managers have performed functional assessments and developed care plans. They may also help arrange for services and supports. Ongoing assessments may be performed to ensure that individuals’ changing needs are met. Case managers may be asked to help resolve crisis situations involving the immediate need for long-term services and supports. In some instances, case managers have been responsible for developing or managing budgets; they may be expected to serve as system gatekeepers or to implement utilization management or cost containment policies when program resources are limited. And, they may monitor the quality of the services and supports that consumers use.

With changes in the nature of available services and supports, more case managers serve as sources of information about available LTSS options. Case managers may provide information about the eligibility criteria and application process associated with particular programs and they may take on counseling roles to help consumers make informed decisions regarding the options available to them. Case managers have not traditionally performed tasks such as recruiting, hiring, or managing workers, but they may play educational or advisory roles for consumers who have taken on these tasks themselves.

A substantial vocabulary has developed as the functions ascribed to case managers have expanded and the types of available long-term services and supports have increased. Terms used in the professional literature to refer to individuals engaged in the more traditional as well as newer activities associated with “case management” include: care manager, counselor, options counselor, case worker, care coordinator, service coordinator, support coordinator, systems navigator, community guide, and

community living specialist. As part of efforts to emphasize the principles of self-determination in LTSS programs, other terms have been introduced: consultant, advisor, monitor, decision assistant, support team member, circle of support member, care guide, and community guide. Terms often associated with programs that involve the development of individual budgets and self-direction of services and supports are: support broker, service broker, and resource manager. An emphasis on helping people make transitions from institutional to community-based care has spawned the terms transition coordinator, relocation coordinator, and relocation specialist. In general, the proliferation of terms reflects a shift from more prescriptive to more consultative or supportive roles. Throughout this brief, the term “case manager” is generally used to refer to individuals performing a broad range of activities.

As with other Medicaid services, states’ approaches to providing case management differ. The service delivery system that has operated historically as well as political and economic circumstances in each state have an impact on the choices states make about how they structure their Medicaid LTSS systems and about the roles case managers play. Within states, case managers’ roles may differ depending on the program with which they are associated and the level of resources available to support case management activities.

This Issue Brief draws on the professional literature as well as on interviews with officials in states to describe current case management efforts and to discuss activities and policies that can enhance states’ efforts to help consumers manage the services and supports they need. The discussion is relevant not only for policy makers involved with the delivery of Medicaid-financed long-term services and supports. It also pertains to the broader goal of improving service and care coordination. The ACA contains initiatives to improve the coordination of primary and specialty care, acute and long-term care for Medicaid and Medicare beneficiaries and for the broader populations. State and program experience with case management can help inform deliberations about how to best implement these initiatives.

### **Use a person-centered approach**

As LTSS systems in states evolve, an important consideration is whether operations, including case management functions, are more closely associated with programs or with consumers. One practical reason for using a program-centered approach is that reimbursement for particular services has been tied to programs or initiatives. More recently, with expanded service options and greater recognition that individuals’ conditions and needs are not static, most states are placing more emphasis on planning around a person’s current and changing preferences and needs. This approach requires that case managers be more familiar with the range of available services and supports than they would be if they worked with just one program.

### **Provide continuity for consumers**

Continuity is an important feature of person-centered case management. Relationships between case managers and consumers may be more satisfying and effective if they are ongoing rather than episodic. From an administrative perspective, there may be some efficiency if consumers only have to provide information once rather than several times to several different people.

A variety of strategies are used in states to promote continuity. One is to have a single case manager work consistently with a consumer. A team approach allows professionals to specialize, but helps ensure that services and supports are coordinated. In **Minnesota**, teams of long-term care consultants include at least one social worker and one public health nurse as well as specialists who act as

consultants. An important detail in using the team approach is to be sure that the role of each team member is clearly delineated.

The use of technology can also promote person-centered case management and continuity when electronic systems are designed so that the work done by one professional is immediately accessible to others. An electronic system is used to make assessments and to develop care plans and monitor services in **Oregon**. A number of different professionals have access to it. In most instances, case managers who perform assessments at the local offices continue to work with consumers as they receive long-term services and supports. In larger metropolitan areas, different case managers may be involved with intake and assessment and with ongoing functions, but both have access to information in the electronic system.

Significant structural changes have also been made in the interest of providing person-centered services and supports. In **New Jersey**, the new *Global Options* waiver combines three prior waivers, all of which targeted consumers who are age 65 or older or between the ages of 21 and 64 and have physical disabilities. The rationale for consolidating the waivers was that people move from setting to setting. Formerly, each time that occurred they had to dis-enroll from one waiver and re-enroll in another. The combined waivers help achieve better continuity of care and reduce confusion for consumers. The same people are receiving different services but are able to stay enrolled in the waiver program even as their needs change. Once they are enrolled in the waiver, they can receive any appropriate services. With the combined waiver in place, staff time and administrative paperwork were reduced. The state was able to eliminate two administrative positions that had been needed to coordinate the dis-enrollments and re-enrollments.

The *Global Options* waiver includes a new service called “transitional care management.” Once a consumer in an institution is identified as a candidate for transition to the community a team comprising both transition and other professionals works with the consumer to achieve the transition. *Community Choice* counselors and county care managers are part of the team. Both participate in the transition process and both are knowledgeable about services in the county.

Forthcoming regulations from CMS may provide more opportunities for states to consolidate waivers. An Advance Notice of Proposed Rulemaking issued in June 2009 solicited comments on changes to the HCBS waiver program to give states the option to serve more than one target population under a waiver. The change is intended to promote person-centered, needs-based services and supports.<sup>iv</sup>

#### **Specialization may be warranted in certain circumstances**

As states adopt new initiatives, some conclude that case managers should specialize in particular activities. This may be a practical decision based on the type and level of reimbursement associated with the initiatives and on the states’ current ability to blend funding streams. (See Appendix) Administrative resource constraints may also affect states’ decisions about how case managers operate. When special training is required, states may decide, at least initially, that they cannot afford to train large numbers of case managers. The choice to have case managers specialize may be a philosophical one; some state officials believe that special skills are needed to support consumers who want to direct their own services. Others note that case managers who help consumers make the transition from institutions to the community can be more effective if they have detailed and current knowledge about local resources.

In **Texas**, relocation specialists are familiar with all of the pertinent local resources such as housing, transportation, the mental health authority, or Centers for Independent Living. Helping with the relocation from institutions to community-based settings is considered to be a more intensive time-consuming job than other case management tasks. Relocation specialists follow up for three months once the consumer is in the community. At that point, the relocation specialists function more as advocates for consumers; they collaborate when service coordinators from managed care organizations are also working with consumers in the community, but continue to take the lead on issues such as housing. In **Maryland**, certain case managers function as housing specialists. **Oregon's** experience is instructive. When the state saw an increase in their nursing facility census for the first time in 20 years, they created a new position, "diversion/transition specialist." Specialists in each region of the state identify people interested in arranging for community-based services, then work with them through a diversion or transition process, for up to 90 days. The specialists are part of a team that may include other case managers who stay involved over the longer term. In the two years since the position was created, the trend had been reversed; nursing home admissions have decreased.

### **Ensure that case managers' roles are clearly defined**

In some instances, it may be necessary to reconcile competing goals for care managers. Traditionally, in conducting assessments and making care plans, many case managers have played both "gatekeeper" roles making recommendations or decisions from the perspective of the state, and they have been advocates for consumers. Commonly they have been asked to balance these roles. States such as **Oregon** and **Washington** that use automated systems with built in logic have a more consistent and objective means to assess need and develop care plans. This leaves case managers freer to work as partners with consumers.

As long-term service and support systems and the variety of programs and tasks associated with case management change, there is a need to clearly define case managers' roles. The trend in case management is from a prescriptive to a more supportive model.

### **Case managers can play an important role with consumer-directed services**

Case managers' changing roles are most evident when states incorporate consumer direction in their LTSS programs. When consumers or their surrogates determine which services they need and are given a cash allotment to hire and supervise direct-service workers, case managers may be asked to perform more counseling, training or monitoring and to be less involved in decision-making than they have been traditionally.

All in-home services are self-directed in **Oregon**. Case managers are quite involved, initially, in helping plan for services. This includes working with consumers who are not inclined or feel they cannot direct their own services to help them designate a representative to direct their in-home services.

Participants in **Arkansas's** waiver program for adults with physical disabilities work with Counseling Support Managers, who provide orientation to the concept of consumer-direction and training on how to recruit, interview, hire, evaluate, supervise, manage or dismiss attendants. The managers also work with individuals to ensure that needs are met as they continue to live independently. In **Vermont's** *Flexible Choices* program, a consultant works with consumers to establish budgets. Consumers may purchase case management services if they desire.

Some self-direction programs provide participants with a traditional case manager and a counselor. This approach requires that program staff understand their respective roles and responsibilities and work collaboratively.

### **Case management should be “conflict-free”**

The *State Balancing Incentive Payments Program* in the Affordable Care Act requires “conflict-free case management services.” The intent is to eliminate potential conflicts of interest that may occur when a service provider employs the person who helps make determinations about or arrangements for services and supports.

Many states have policies in place already to ensure that functional eligibility assessments are performed by entities not involved with the provision of services. In **Maine**, nurses employed by an agency independent of the state conduct the assessments, establish functional eligibility, and authorize a service plan. Case managers then arrange for and coordinate services. In **Texas**, a third party vendor uses a single assessment tool to make functional eligibility determinations for both institutional and community-based care and establishes cost caps for waiver services. In **Minnesota**, certified assessors will administer the *MNCHOICE* tool. New state policies differentiate between certified assessors and case managers; there will be instances when case managers will also serve as certified assessors, but not for consumers who they assist in a case management capacity. Although separate individuals will perform the two functions, case managers will have access to assessment results and to the information provided for the assessment because *MNCHOICE* is an electronic tool that accommodates information sharing.

For philosophical and practical reasons, the extent to which ongoing case management activities are separate from the provision of other services varies among states. Some systems have developed based on the belief that service providers are in the best position to help manage care because they are most familiar with the consumer and can provide some continuity. Others are structured to promote collaboration even if the case manager and service provider are not employed by the same entity. Provider supply is a factor that affects state policies about who provides particular services. Areas with provider shortages may not have the capacity to provide case management separate from other services.

States where service providers may employ case managers use various methods to attempt to avoid conflicts of interest. One is to give consumers a large number of choices of providers. In **New Jersey**, for example, most case managers were associated with Area Agencies on Aging, but over the past five years the state has worked to expand the pool of providers and now works with Visiting Nurse Associations, Centers for Independent Living, and for-profit home care agencies. Consumers are asked to sign a document indicating that they have chosen their service providers. To be most effective, states should not only increase the number of providers, but also help consumers differentiate among them by providing descriptive information or a means by which consumers can share information about their experiences with various providers. This approach may also require more monitoring of case management activities on the part of the state.

States also rely on state employees to provide oversight. In **Vermont**, for example, case managers are employed by Area Agencies on Aging and home health agencies; home health agencies are also service providers. Long-term care clinical coordinators, nurses employed by the state, not only conduct initial assessments when consumers seek services, but also review and approve the care plans developed by



the agencies. This type of oversight role may be difficult to sustain, however, if limited resources force states to reduce staff. States also use satisfaction surveys to get input from consumers regarding case management activities.

### **Case managers' roles within managed care organizations should be well defined**

The use of managed care arrangements for long-term services and supports raises a similar issue – how to ensure that appropriate services and supports are provided when the case manager and service providers work for the same entity – but the incentives in managed care are somewhat different. By design, case management organizations rely on close collaboration between case managers and service providers, but they may also have financial incentives to minimize services if they are paid under capitated arrangements. A CMS publication from the *Workgroup on Managed HCBS* notes that with carefully constructed contract language states can have access to useful data to measure quality when they contract with managed care organizations.<sup>v</sup>

In **Wisconsin's** *Family Care* program, the care management team associated with each care management organization develops a care plan for each consumer. The plans are reviewed by an impartial entity, the *External Quality Review Organization*, to assure that the services and supports for the consumer are appropriate and in line with the web-based functional screen conducted initially by the ADRC. This monitoring occurs on an annual basis. The **Arizona** Medicaid program conducts all financial and functional eligibility determinations first and then care managers at managed care organizations develop service plans. The care manager sees each consumer every ninety days. The managed care organizations track performance in terms of timeliness and services authorized and can identify case managers who miss deadlines or authorize more or fewer services than the norm. Each organization submits annual reports to the state with details of case management monitoring. In addition, the state monitors activities independently each year using methods such as chart reviews or consumer satisfaction surveys.

### **Provide adequate training and support for case managers**

Since case managers play an important role in helping consumers evaluate options and make decisions about the types of services and supports that are needed, their attitudes, beliefs, and practices can have an impact on the choices consumers make and can affect the success of states' efforts to change their LTSS systems. Training may be needed as new programs or initiatives are introduced. Experience in states suggests that multiple training sessions can be helpful, particularly when there is a shift in case managers' roles. But constrained resources have limited training opportunities in states.

Training that emphasizes adjustments in attitude as well as process may be needed when case managers are asked to act as facilitators rather than decision makers and when there is a program shift to take consumers' strengths and preferences into account to a greater extent than occurred previously. A review of challenges states face in expanding consumer-directed LTSS programs notes that case managers who play a key role in traditional home and community-based waiver programs are resistant to consumer direction. When introduced to the concept of consumer direction case managers expressed concern that the process is too complicated for older consumers. They questioned the adequacy of budget amounts even when the amounts are similar to the cost of services they had previously prescribed, and they worried about the potential for fraud though experience provided no basis for the concern.<sup>vi</sup>

In recognition of the need to provide training for case managers, CMS developed a web-based training video program that reviews the basics about HCBS waiver programs and provides guidance about the roles that case managers are asked to play.<sup>vii</sup>

Individual states have substantial experience with case management training. **Vermont** has established a certification program for case managers. In its training program for case managers, **Texas** emphasizes person-centered planning which focuses on consumers' preferences including consumers' right to assume risk in developing their care plans. The state has included consumer-directed services in all of its state plan programs and waivers. **Maryland's** *Money Follows the Person* program has done extensive training focused on changing case managers' philosophy from one of "caring for" consumers to one that promotes choice and emphasizes consumers' individual preferences. Training sessions are held for case managers at least four times a year. In one instance the state hired a consultant familiar with person-centered planning to facilitate a session with a consumer, the family, the case manager, and the nurse who reviews LTSS plans, to resolve several difficult issues so that the consumer could remain in the community. The session was videotaped and will be used for training purposes. Reports from **Michigan, Minnesota, and Rhode Island** indicate that a particularly effective strategy is to find a few champions among case managers who are well respected by their peers and ask them to help convince others that the new approach is effective.<sup>viii</sup>

In some instances, case managers may simply need more or better information about new policies in order to implement them effectively. In **New Jersey**, care managers working with the *Global Options* waiver receive core training as well as training on special topics every six months. When state staff saw that few consumers were using the available *Participant Employed Provider* option, they held a training session to better explain some of the operational details, such as how the third party entity that can help with some of the financial and employment issues operates. After the training, case managers were better able to understand and explain the procedures associated with the new option and use of the option increased.

**Oregon** is able to tailor ongoing training efforts based on reviews of system data, such as client assessment profiles. When patterns emerge, such as a spike in the numbers approved for services at a particular acuity level or for a particular reason, trainers can work with case managers to help ensure that they are using the assessment tool correctly. Calls to the state from consumers and local offices requesting technical assistance were the impetus for another training effort to help case managers evaluate the natural support available from family and friends when assessing needs.

State officials stress the need for ongoing training. For example, when **Wisconsin** introduced the *Family Care* program, which emphasizes individual preferences and goals, case managers received extensive training about program philosophy as well as practical details. Over time state officials have seen a need to send trainers back into the field, particularly in certain parts of the state, to emphasize the importance of taking individual preferences into account.

Officials also say that training may also occur less frequently than is ideal. In **New Jersey**, all agencies and organizations are required to have their care managers complete core care management training. Previously the requirement was to have care managers trained in the 12 months after they are hired. Now there is an 18-month requirement for training. The extended time period is necessary because the state has lost staff and does not have the ability to hold training sessions as often.



**Oregon** also reports that training for case managers is less robust now than it has been. Formerly, before they saw consumers, all new case managers attended a two-week training program to become well versed not only in the technical aspects of the program, but also with the strength-based approach used in the program. Now the same core curriculum is used, but training is not always completed before case managers see consumers. Some of the training is done in person, but interactive computer training and video conferencing also are used.

## **CONCLUSION**

Case management and care coordination have long been recognized as important functions in Medicaid community-based long-term service and support programs. Case managers' roles have evolved as options for care have increased and particularly as consumers have taken a more active role in directing their own services. Several of the challenges that state Medicaid programs face as they consider how best to provide case management are also relevant as policy makers think about how to coordinate care more broadly, particularly as they plan to implement some of the care coordination initiatives in the Affordable Care Act. Issues of interest include: clear definitions for case managers' roles and responsibilities; reimbursement policies that foster person-centered services rather than policies that tie payment for case management or similar services to particular programs or initiatives; and arrangements between case managers and service providers in both managed care and fee-for-service systems that do not risk conflicts of interest.

The Medicaid experience indicates that adequate training and ongoing support help in implementing program policies effectively. Also, when funds are available, investing in technology makes good sense. The use of sophisticated electronic systems can help states make objective and consistent recommendations for services and supports, facilitate communication, monitor services, inform training efforts, and assure quality.

Any discussion of attempts to coordinate long-term services must recognize the need to coordinate long-term and acute services and supports, which has the potential to improve continuity of care, reduce duplication of services, and save money. Case management services will continue to be an important feature as new care and service delivery systems are developed, many in response to initiatives in the Affordable Care Act.

This issue brief was prepared by Laura Summer of the Georgetown Health Policy institute and Jhamirah Howard of the Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation.

## **Appendix: Reimbursement for Case Management Services Associated With Community-Based Long-Term Services and Supports Financed by Medicaid**

States have options for the way they are reimbursed by Medicaid for case management services.

Case Management and Targeted Case Management are separate optional Medicaid services that states may elect to cover. Case management is defined by CMS as services that help beneficiaries gain access to needed medical, social, educational and other services, such as assessment, care plan development, referral, and monitoring and follow-up. Targeted case management (TCM) services are aimed at specific Medicaid beneficiary groups or for individuals who reside in state-designated geographic areas as well as for individuals enrolled in HCBS waivers. Reimbursement for the service is at the state's FMAP rate.

Services provided under 1915(c) Home and Community-Based Waivers may include case management, which is defined as activities that help consumers gain access to needed waiver and other State plan services, as well as needed medical, social, educational, and other appropriate services regardless of the funding source for the services." Reimbursement for the services is at the state's FMAP rate. When case management services are associated with transitions from institutions to the community, the services can be delivered up to 180 days prior to discharge, but may only be claimed on the date the person leaves the institution and is enrolled in the waiver and is receiving at least one service (claimed as a special single unit of transitional case management). Reimbursement is not available if the consumer does not leave the institution.

Money Follows the Person initiatives may include case management services related to transition from an institution to the community. Reimbursement for these services is available at an enhanced federal match rate (75-90% FMAP) for a 12-month period for each person who successfully transitions to the community. States have other reimbursement options for case management services if the person does not make a successful transition to the community.

Case Management as an administrative activity is another reimbursement option for states. Under this option, case management services must be related to covered Medicaid services. Reimbursement is available for services provided for consumers prior to their leaving an institution. Administrative activities are reimbursed at a 50 percent matching rate.

Medicaid funds the provision of information and assistance, that is, counseling in self-direction programs) whether as a service or as an administrative expense. "Counseling can be added to case management or a new service can be created. Programs designed in this manner are eligible for FFP at the enhanced service rate and must provide participants with free choice of providers"

Managed care organizations may provide case management services. Payment for these services is included in the capitated rate paid to health plans for enrolled members.

---

<sup>i</sup> Kaiser Commission on Medicaid and the Uninsured, *Medicaid and Long-Term Care Services and Supports*, February 2009.

<sup>ii</sup> Eiken, S., K. Sredl, B. Burwell, L. Gold, *Medicaid Long-Term Care Expenditures in FY2009*, Thomson Reuters, August 2010.

<sup>iii</sup> The Affordable Care Act (ACA) refers to the Patient Protection and Affordable Care Act, P.L. 111-148, enacted March 23, 2010, together with the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, enacted March 30, 2010.

<sup>iv</sup> Federal Register: Advance Notice of Proposed Rulemaking, June 22, 2009 (Volume 74, Number 118).

<sup>v</sup> CMS Regional and Central Office Workgroup on Managed HCBS, *Providing Long Term Services and Support in a Managed Care Delivery System, Enrollment Authorities and Rate Setting Techniques: Strategies States May Employ to Offer Long Term Services and Supports through a Managed Care Delivery System, CMS Review Processes and Quality Requirements*, Centers for Medicare and Medicaid Services, December 2009.

<sup>vi</sup> Doty, P., K. Mahoney, M. Sciegaj, "New State Strategies to Meet Long-Term Care Needs," *Health Affairs* 29, no 1, January 2010.

<sup>vii</sup> Available at <http://www.hcbsassurances.org/>

<sup>viii</sup> Doty, P. et al, January 2010.

1330 G STREET NW, WASHINGTON, DC 20005  
PHONE: (202) 347-5270, FAX: (202) 347-5274  
WEBSITE: WWW.KFF.ORG/KCMU

This publication (#8145) is available on the Kaiser Family Foundation's website at [www.kff.org](http://www.kff.org).



The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.